IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

IN RE APPLICATION OF:	WILLIAM D. KIRSH *ET AL.*	EXAMINER:	R.W. MORGAN
APPLICATION NO.:	09/784,045	ART UNIT:	3626
FILED:	FEBRUARY 16, 2001	CONF. NO:	2531

FOR: **SYSTEM AND METHOD FOR STANDARDIZED AND AUTOMATED APPEALS PROCESS**

MS Appeal Brief - Patents
Commissioner for Patents
P.O. Box 1450
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AMENDED BRIEF ON APPEAL UNDER 37 C.F.R. §41.37

This amended brief is filed in response to a Notification of Non-Compliant Appeal Brief. Appellants are appealing the final rejection of claims 1-11, 14-21 and 23 dated November 3, 2006. A Notice of Appeal was filed on February 5, 2006. Appellants request that the rejection of claims 1-11, 14-21 and 23 be reversed.

(1) Real Party in Interest

The real party in interest is e-Appeals, LLC, of Hollywood, Florida, the assignee of the above-captioned application.

(2) Related Appeals and Interferences

There are no related appeals or interferences known to Appellants.

(3) Status of Claims

Claims 1-23 are pending and have been rejected. Claims 1-11, 14-21 and 23 are being appealed. Claims 12, 13 and 22 are not on appeal. A copy of the appealed claims as they presently stand is included in the Claims Appendix.

(4) Status of Amendments

No amendments have been filed subsequent to the final Office Action mailed on November 3, 2006.

(5) Summary of Claimed Subject Matter

The following description relates to independent claims 1-4, 7, 8, 11, 14, 15, 21, and 23. All of Appellant's pending independent claims on appeal relate to the automated processing of insurance appeals, and in particular, appeals relating to healthcare insurance claims. Healthcare insurance and appeals relating to that insurance are typically governed by contract and are regulated by state and federal law. An insurance appeal may arise when an insurance company has made a determination that is unfavorable to an insured concerning whether the insured is entitled to a benefit or service in accordance with an insurance contract or under a law. An appeal may be filed either by a consumer, such as a patient, or by a provider, such as a physician. As examples, a consumer may file an appeal when a request for approval to receive medical treatment is denied or a claim is not paid. A healthcare provider may file an appeal when an insurer has not paid for a service rendered. (Page 1, lines 12-18.) Often, claims are denied because either information is missing from the claim form or the provider contract is loaded incorrectly into an insurance company database. (Page 2, lines 20-22.)

The specification describes systems and methods for a standardized and automated appeals process over a network for appealing denials of these insurance claims and other types of benefits. (Page 1, lines 3-5.) Independent claims 1-4, 7, 8, 11, 14, 15, 21, and 23 recite combinations of receiving appeals data, processing the data, and forwarding the processed data to a payer such as an appeals agency. In connection with independent claims 1-4, 7, 8, 11, 14, 15, 21, and 23, the specification describes that information relating to the user and the user's appeal is received from a user or remote station. (Page 15, line 6-page 19, line 6 and page 24, line 4-line 14.) The received data is stored and further processed so that it can be

later presented to a payer in a standardized format. (Page 24, lines 15-20.) This processed data is then sent to an appeals agency, appeals unit, or other form of payer for reconsideration. (Page 19, line 15-page 20, line 15 and page 21, line 16-page 22, line 5.) During the appeal process, the user can be notified of the status of the appeal. (Page 26, lines 1-2.) Independent claim 23 further recites automatic identification of a regulatory agency for an appeal. (Page 11, lines 4-7, page 21, lines 7-10, and page 26, lines 7-14.)

(6) Grounds of Rejection to be Reviewed on Appeal

(a) The rejection of claim 23 as containing new matter is appealed.

(b) The rejection of claims 1, 3, 4, 6-8, and 14 as obvious in light of Burchetta is appealed.

(c) The rejection of claims 2 and 11 as obvious in light of Burchetta in combination with Israel is appealed.

(d) The rejection of claim 5 as obvious in light of Burchetta in combination with Barber is appealed.

(e) The rejection of claims 9 and 10 as obvious in light of Burchetta in combination with Official Notice is appealed.

(f) The rejection of claims 15-21 as obvious in light of Burchetta in combination with Newswire is appealed.

(g) The rejection of claim 23 as obvious in light of Burchetta in combination with Newswire and Official Notice is appealed.

(7) Argument

A. Claim 23 does not introduce new matter as alleged in Grounds of Rejection (6)(a).

Claim 23 was rejected under 35 U.S.C. §112, first paragraph, as containing subject matter allegedly not supported by the original disclosure. Claim 23 recites:

> A method for an automated appeal process, comprising:
> receiving appeal data comprising:

data descriptive of a denial of a benefit, service or payment;
an identification of a state in which a health care service was provided; and
an identification of a type of health care insurance;
automatically identifying a regulatory agency appropriate for an appeal, the identification being based upon the identified state and the type of health care insurance in the received appeal data;
generating an appeal submission comprising the data descriptive of the denial of the benefit, service or payment and arranged according to a predetermined format; and
sending the formatted appeal submission to the identified regulatory agency,
wherein the appeal relates to a request for reconsideration of a determination of entitlement to a benefit, service or payment.

The Examiner stated that the claimed feature of "automatically identifying a regulatory agency appropriate for an appeal, the identification being based upon the identified state and the type of health care insurance in the received appeal data" constitutes new matter. The Examiner alleged a lack of support for "automatically identifying a regulatory agency." Appellants respectfully submit that this feature is described in the specification as originally filed.

The specification as originally filed describes that

> [a]fter selecting the "Escalate" function from FIG. 2-138, the system identifies the regulatory agency appropriate for the appeal as identified in the appeal database 124 based upon the association between the state in which the health care service was performed and the recorded line of business (HMO, Commercial, Medicare, etc.) included in the appeal data.

Specification at page 21, lines 7-10. This portion of the specification discloses that "the system" identifies an appropriate regulatory agency. The description in the specification that the identification is performed by "the system" is a disclosure to one of ordinary skill in the art that the identification is performed "automatically." The specification further describes that "[t]he automated appeals system uses electronic connections to link providers, patients and payers…It uses the application of computer communications and data processing capacity to

automate the entry, transmission, processing, and storage of information." (Specification at page 11, lines 4-7.) These paragraphs together disclose "automatically identifying a regulatory agency."

Furthermore, the specification is replete with references to the "automated" system and other "automatic" operations. In fact, the application is entitled "System and Method of Standardized and Automated Appeals Process." The specification concludes with a paragraph describing that

> [t]he automated appeals system disclosed herein can be used for a wide range of additional service product categories and more value-added services can be included to further personalize the appeals experience. For instance, all businesses with a regulated or contractual appeals or grievance process would benefit from the automation and standardization offered by this process.

Specification at page 26, lines 7-14, emphasis added. Appellants respectfully submit that the specification as filed discloses automatically identifying a regulatory agency and request that this rejection be reversed.

B. Burchetta does not teach an appeal that relates to a request for reconsideration of a claim adjudicated by an insurer and there is no evidence in the record to support the assumptions relied upon by the Examiner in rejecting claims 1-11 and 14 in Grounds of Rejections (6)(b)-(e).

Claims 1-11 and 14 stand rejected under 35 U.S.C. §103(a) as being unpatentable over U.S. Patent No. 6,330,551 entitled "Computerized Dispute Resolution System and Method" by Burchetta et al. ("Burchetta"), alone or in combination with other references.

Independent claims 1, 2, 3 and 7 of present application recite that "the appeal is a request for reconsideration of a claim adjudicated by an insurer." Independent claims 4, 8, 11 and 14 recite that "the appeal…information relates to a request for reconsideration of a claim adjudicated by an insurer." Burchetta, however, does not describe "a request for reconsideration of a claim adjudicated by an insurer." Rather, Burchetta is directed to "a

computerized system for automated dispute resolution...for communicating and processing a series of demands to satisfy a claim made by or on behalf of a person involved in a dispute with at least one other person and a series of offers to settle the claim." (Burchetta at col. 3, lines 47-52, emphasis added.) Thus, Burchetta only describes an iterative negotiation process whereby two parties can negotiate a specific dollar amount for settlement of a claim.

The Examiner has admitted that Burchetta fails to teach an appeal that is a request for reconsideration of a claim adjudicated by an insurer. (See final Office Action at 5.) The Examiner recognized this shortcoming of Burchetta and stated at page 6 of the final Action that "[t]he Examiner considers a dispute [of Burchetta]...as a claim that has been adjudicated by one of the parties involved such as the insurer." Appellants respectfully submit that Burchetta does not teach or suggest an "appeal" that is "a request for reconsideration of a claim adjudicated by an insurer." Rather, Burchetta only describes a "demand" which is defined by Burchetta to be "the amount of money required by the person having a claim...against another person...such as a defendant or his insurer, for which the person with the claim would be willing to settle." (Burchetta at col. 3, lines 54-57.)

In the final Office Action at page 31, the Examiner stated, and Appellants do not disagree, that Burchetta teaches a computerized system for automated dispute resolution of claims that may or may not be in litigation. In contrast to the claimed invention, however, Burchetta presupposes that a cognizable claim for money against an insurer or another party already exists. The systems and methods recited in the claims are not directed to an individual having a claim for any amount of money. Rather, the pending claims relate to sending information to an appeal unit for reconsideration of a claim adjudicated by an insurer. The claims do not recite a demand for money or the transfer of any amount of money from one party to another, *per se*.

Because Burchetta fails to teach the claimed "request for reconsideration of a claim adjudicated by an insurer," the Examiner attempted to provide that teaching without relying on

Burchetta by simply stating what the Examiner considers the automated dispute process of Burchetta to be. Appellants respectfully submit that the Examiner has impermissibly considered the automated dispute of Burchetta to be as he has described it and has failed to identify any basis in Burchetta for the Examiner's conclusion.

In the Examiner's Response to Arguments on page 31 of the Action, the Examiner stated that "[t]he Examiner considers litigation which is not pending as a claim that has been adjudicated by an insurer..." Appellants submit that it is an insufficient basis for a rejection of the claims that "the Examiner considers" the demand for money disclosed by Burchetta to be the claimed request for reconsideration of a claim that has been adjudicated by an insurer. It is insufficient because the Examiner has failed to provide any evidence at all for his "consider[ation]." The Examiner supported this rejection with a citation to *In re Graves*, 36 USPQ 2d 1697 (Fed. Cir. 1995). Appellants respectfully submit that *In re Graves* does not support the Examiner's rejection here because *In re Graves* requires that the Examiner rely on evidence in the record that one of ordinary skill in the art would make the same consideration. In an analogous situation, the Board in *Ex parte Donaldson* (Unpublished BPAI opinion in Appeal No. 1998-0595), concluded that *In re Graves* was inapplicable:

> As for the Federal Circuit's decision in *In re Graves*..., which the examiner also cited, it appears that the examiner is relying on the notion that what is otherwise known to one with ordinary skill in the art need not be described in a prior art reference. That, however, does not help the examiner's position here, because the examiner has made no demonstration based on evidence in the record that putting a spindle synchronization command...was known to one of ordinary skill in the art.

(*Ex parte Donaldson*, emphasis added.) The only basis for the Examiner's rejection of the pending claims as obvious is a review of Appellant's disclosure and the application of an unsupported consideration. The Examiner's unsupported consideration that the automated dollar disputes of Burchetta are claims that have been adjudicated by an insurer cannot form a basis for a rejection of the claims. The Examiner's basis for the rejection in this case is no

better supported than the basis found to be insufficient in *Ex parte Donaldson* which, while not precedential, is indicative of how the Board addresses this type of issue.

Appellants respectfully submit that the MPEP also suggests that this rejection should be reversed. MPEP §2144.03 relies on *In re Zurko* and states that "[i]t is never appropriate to rely solely on 'common knowledge' in the art without evidentiary support in the record, as the principal evidence upon which a rejection was based. *In re Zurko*, 258 F.3d 1379, 1385, 59 USPQ2d 1693, 1697 (Fed. Cir. 2001) ('[T]he Board cannot simply reach conclusions based on its own understanding or experience-or on its assessment of what would be basic knowledge or common sense. Rather, the Board must point to some concrete evidence in the record in support of these findings.')".

As the court held in *Zurko*, an assessment of basic knowledge and common sense that is not based on any evidence in the record lacks substantial evidence support. *Id.* at 1385, 59 USPQ2d at 1697. See also *In re Lee*, 277 F.3d 1338, 1344-45, 61 USPQ2d 1430, 1434-35 (Fed. Cir. 2002) (In reversing the Board's decision, the court stated "'common knowledge and common sense' on which the Board relied in rejecting Lee's application are not the specialized knowledge and expertise contemplated by the Administrative Procedure Act. Conclusory statements such as those here provided do not fulfill the agency's obligation....The board cannot rely on conclusory statements when dealing with particular combinations of prior art and specific claims, but must set forth the rationale on which it relies.").

Because Burchetta fails to teach "a request for reconsideration of a claim adjudicated by an insurer" and the Examiner cannot rely on unsupported considerations to fill that gap, Appellants respectfully request that the rejection of claims 1-11 and 14 be reversed.

C. Burchetta does not teach an appeal that relates to a request for reconsideration of a determination of entitlement to benefits or services and there is no evidence in the record to support the assumptions relied upon by the Examiner in rejecting claims 15-21 and 23 in Grounds of Rejections (6)(f)-(g).

Claims 15-21 and 23 were also rejected under 35 U.S.C. §103(a) as being unpatentable over Burchetta. Independent claims 15 and 21 recite that "the appeal relates to a request for reconsideration of a determination of entitlement to benefits or services." Independent claim 23 recites that "the appeal relates to a request for reconsideration of a determination of entitlement to a benefit, service or payment."

On page 23 of the Action, the Examiner stated that this feature is taught by the description in Burchetta of a central processing unit that receives information corresponding to three settlement offers and that a plaintiff or claimant can enter three demands over a period of time. (See Burchetta at col. 2, lines 3-6.) While Appellants acknowledge that Burchetta teaches receipt of a series of demands and offers, Appellants respectfully submit that Burchetta does not teach or suggest any form of "appeal" that "relates to a request for reconsideration of a determination of entitlement to benefits or services."

As discussed above, Burchetta is not analogous and is completely unrelated to the claimed invention. Burchetta describes only that a "demand" is "the amount of money required by the person having a claim...against another person...such as a defendant or his insurer, for which the person with the claim would be willing to settle." (Col. 3, lines 54-57.) Burchetta describes that an "offer" is "the amount of money the defendant or the insurance company will settle the claim." (Col. 3, lines 61-63.) Thus, the offer and demand of Burchetta are nothing more than dollar amounts. Burchetta describes a process whereby two parties can agree, through a negotiation process, on a dollar amount to be paid on a claim. Burchetta does not describe anything that relates to a "determination of entitlement."

On page 31 of the final Office Action, the Examiner appeared to acknowledge that Burchetta does not teach the claimed feature. The Examiner stated that "the Examiner interprets the series of demands and offers as requests for reconsideration of a determination of entitlement to benefits or services." Appellants respectfully submit that, as discussed above, the Federal Circuit and the Board have found that this type of unsupported consideration cannot form a basis for a rejection of the claims and respectfully request that the rejection of claims 15-21 and 23 be reversed.

D. Newswire does not teach selecting a reason for an appeal of a denial as alleged in Grounds of Rejection (6)(f)-(g).

Claims 15-21 and 23 stand rejected under 35 U.S.C. §103(a) as unpatentable over Burchetta in view of a press release entitled "Cardiff Software Announces TELEform MediClaim Module" ("Newswire").

Newswire teaches software for automated medical claims processing. Newswire describes that the software begins by optically scanning handwritten or machine print medical claim forms. After recognition, the data is then validated. Newswire teaches, at paragraph 13, that the validation step includes checking for mismarked or illegible entries, correcting errors, and checking all fields for formatting and content. After validation, the software can export data in certain standard formats. Thus, the validation of Newswire is nothing more than a check to confirm that the data read in does not have obvious faults.

In rejecting claims 15-21 and 23, the Examiner recognized that Burchetta fails to teach associating appeal data with one or more bases for an appeal and turned to Newswire to complete the obviousness rejection. Appellants submit that Newswire also fails to teach the features of "automatically selecting a reason for an appeal of the denial, the selection being based upon the appeal data" of claim 15 or "processing the stored appeal data to identify a basis for an appeal" of claim 21.

Appellants do not disagree with the Examiner that Newswire teaches a MediClaim module that performs optical character recognition (OCR) and validation on medical claim information. (Final Office Action at page 24.) However, Appellants respectfully submit that Examiner has misinterpreted the validation step to include generating a reason for an appeal. Appellants submit that Newswire is unrelated to the claimed invention and does not teach "selecting a reason for an appeal."

Appellants submit that Newswire fails to teach selecting a reason for an appeal based upon appeal data, automatically or otherwise. Newswire does not teach a system capable of selecting a reason of any kind for any purpose. Newswire teaches a very simple system that performs OCR on medical claim data and then checks that data to ensure that it complies with certain conventions. There is no suggestion that an appeal has taken place or will take place. There is also no suggestion of a basis for such an appeal.

In the final Office Action at page 25, the Examiner stated that the customized validations on ICD-9 and CPT data teach "data descriptive of a plurality of insurance appeals." Appellants submit that one of ordinary skill in the art would recognize that ICD-9 and CPT data are diagnostic and treatment coding schemes. These schemes provide standardized codes for medical procedures and have the general purpose of facilitating billing and data collection for medical procedures and conditions. Even if the codes referenced in Newswire could somehow be used in connection with an insurance appeal, there is no suggestion anywhere in Newswire that these standardized codes can be the basis for selecting a reason for an insurance appeal.

Appellants therefore respectfully request that the rejection of claims 15-21 and 23 be reversed.

E. The prior art fails to teach automatically identifying a regulatory agency as alleged in Grounds of Rejection (6)(g).

The Examiner rejected claim 23 as unpatentable over Burchetta in combination with Newswire and further in view of Official Notice.

The rejection of claim 23 appears to rely upon Newswire to teach the claimed feature of "an appeal submission…according to a predetermined format." As discussed above, Newswire never mentions an appeal and therefore does not teach an appeal submission…according to a predetermined format.

In rejecting claim 23, the Examiner recognized that neither Burchetta nor Newswire teach the claimed feature of

"receiving appeal data comprising…

an identification of a state in which a health care service was provided; and

an identification of a type of health care insurance;

automatically identifying a regulatory agency appropriate for an appeal, the identification being based upon the identified state and the type of health care insurance in the received appeal data."

To complete the obviousness rejection, the Examiner took Official Notice "that in the medical industry state laws and regulations provide guidance to physician and patient in determine [sic] reimbursement amounts of appeal information for health insurance claims." The Examiner then concluded that "it would have been obvious to…include identifying the state and type of health care insurance regarding the appeal information with the system [of Burchetta and Newswire]."

Appellants submit that the Examiner has not made a prima facie case of obviousness. The Examiner has not alleged that any prior art reference teaches "automatically identifying a regulatory agency… the identification being based upon the identified state and the type of health care insurance."

Furthermore, Appellants do not concede that it is a common fact appropriate for Official Notice that "laws and regulations…determine reimbursements amounts of appeal information." Reimbursement amounts in this context are more properly a matter of contract between the insured and insurer. Appellants are unaware of any law or regulation that mandates reimbursement amounts on an appeal and the examiner has not identified any such law or regulation. Appellants further submit that the Official Notice, even if based on well-known facts or common knowledge, is insufficient to support the rejection. The purported fact that medical industry regulations inform parties of reimbursement amounts for insurance claims is irrelevant to and fails to teach "automatically identifying a regulatory agency appropriate for an appeal."

It is axiomatic that in forming an obviousness rejection, each claimed feature must be identified in the prior art. In rejecting claim 23, the Examiner recognized that the prior art fails to teach certain claimed features, took Official Notice of a purported fact that also does not teach the missing feature, and then rejected the claim as obvious in light of that purported fact. Appellants submit that the Examiner has not identified any teaching of "automatically identifying a regulatory agency appropriate for an appeal" in the prior art. Appellants therefore respectfully request that the rejection of claim 23 be reversed.

F. Conclusion

Appellants submit that the pending dependent claims are also patentable for the reasons given above and respectfully request reversal of the rejections.

In the event that the U.S. Patent and Trademark Office determines that an extension and/or other relief is required, Appellants petition for any required relief including extensions of time and authorize the Commissioner to charge the cost of such petitions and/or other fees in connection with the filing of this document to Deposit Account No. 50-0665 referencing docket no. 621848001US.

Respectfully submitted,
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Claims Appendix

1. A method for an automated appeal process for a provider, comprising:

receiving provider identification from a remote provider station;

receiving appeal data from the remote station, wherein the appeal data comprises data descriptive of a plurality of insurance appeals;

storing the appeal data from the remote station;

sending the appeal data to an appeals unit;

receiving appeal status information for a plurality of appeals from the appeals unit; and

sending appeal status information to a provider at the remote station,

wherein the appeal is a request for reconsideration of a claim adjudicated by an insurer.

2. A method for an automated appeal process for a user, comprising:

collecting user information and appeal data from a user;

electronically storing the collected data in a database;

sending the appeal data to an appeals agency;

receiving a status of an appeal from the appeals agency;

storing the status of the appeal; and

sending the status of the appeal to the user,

wherein the appeal is a request for reconsideration of a claim adjudicated by an insurer.

3. A system for an automated appeal process for a user, comprising:

a server connected to a remote station for receiving appeal data from the remote station; and

a database for storing the appeal data,

wherein the server is further configured or arranged to:

transmit an appeal form to the user at the remote station;

receive an appeal form containing appeal data from the user;

process the appeal form to generate an appeal having a predetermined format;

send the formatted appeal to an appeals unit; and

send a status report to the user at the remote station,

wherein the appeal is a request for reconsideration of a claim adjudicated by an insurer.

4. A method of automating an appeals process, comprising:

electronically collecting user information from a user and storing the user information;.

presenting the user with a claim denial form;

collecting claim denial information and storing the claim denial information;

presenting the user with a patient information form;

collecting patient information and storing the patient information;

presenting the user with a provider information form;

collecting provider information and storing the provider information;

collecting appeal status information on an adjudicated claim and storing the appeal status information;

presenting the user with a check appeal status form; and

collecting check appeal status information and presenting the user with appeal status information based on the check appeal status information collected,

wherein the appeal status information relates to a request for reconsideration of a claim adjudicated by an insurer.

5. The method according to claim 4, further comprising:

presenting the user with a credit card information form; and

collecting credit card information and storing the credit card information.

6. The method according to claim 4, further comprising presenting an administrative interface including information on an appeal submitted.

7. A method for an automated appeal process, comprising:

receiving a login request from a user;

electronically presenting a welcome screen to the user;

receiving a first user selection from the user;

presenting a first user screen based on the first user selection;

receiving user identification information from the user;

presenting a second user screen based on the user identification information;

receiving a second user selection from the user; and

presenting a third user screen based on the second user selection, the third user screen for a new appeal,

wherein the appeal is a request for reconsideration of a claim adjudicated by an insurer.

8. A method for automating an appeal process, comprising:

receiving appeal data descriptive of a plurality of appeals from a remote station;

converting appeal data from one or more of the plurality of appeals to a predetermined appeal format; and

sending at least a portion of the converted appeal information to an appeals unit,

wherein the appeal information relates to a request for reconsideration of a claim adjudicated by an insurer.

9. The method of claim 8, wherein the conversion further comprises converting the information to conform with a format described by a public law.

10. The method of claim 8, wherein the conversion further comprises converting the information to conform with a format described by a public regulation.

11. A method for automating an appeal process, comprising:

receiving appeal data descriptive of a plurality of appeals from a remote station;

converting appeal data from one or more of the plurality of appeals to a predetermined appeal format;

applying one or more rules to select one or more of the plurality of appeals; and

sending data descriptive of one or more selected appeals to an appeals agency,

wherein the appeal information relates to a request for reconsideration of a claim adjudicated by an insurer.

14. A method for an automated appeal process, comprising:

collecting user information and appeal data from a data provider;

electronically storing the collected data in a database;

sending the appeal data to an appeals unit;

receiving a status of an appeal from the appeals unit;

storing the status of the appeal; and

sending the status of the appeal to the data provider,

wherein the appeal information relates to a request for reconsideration of a claim adjudicated by an insurer.

15. A method for an automated appeal process, comprising:

receiving appeal data descriptive of a denial of a benefit, service or payment;

automatically selecting a reason for an appeal of the denial, the selection being based upon the appeal data;

generating an appeal submission including the selected reason for an appeal and arranged and according to a predetermined format; and

sending the formatted appeal submission to an appeals agency,

wherein the appeal relates to a request for reconsideration of a determination of entitlement to benefits or services.

16. The method of claim 15, wherein the selection of a reason for an appeal is based on results of a previously submitted claim or appeal.

17. The method of claim 15, wherein the appeal data comprises data descriptive of a plurality of insurance appeals.

18. The method of claim 15, further comprising extracting available data elements from a standardized data form.

19. The method of claim 18, wherein the standardized data form is an HCFA 1500, NSF version 2.0 or 3.0 UB92, or ANSII data form.

20. The method of claim 18, wherein the standardized data form is a HIPAA 835 or HIPAA 837 data form.

21. A method for an automated appeal process, comprising:

receiving appeal data from a remote station;

storing the appeal data from the remote station in a database;

processing the stored appeal data to identify a basis for an appeal;

generating an appeal submission comprising the identified basis for the appeal and according to a predetermined format; and

sending the formatted appeal submission to an appeals unit,

wherein the appeal relates to a request for reconsideration of a determination of entitlement to benefits or services.

23. A method for an automated appeal process, comprising:

receiving appeal data comprising:

data descriptive of a denial of a benefit, service or payment;

an identification of a state in which a health care service was provided; and

an identification of a type of health care insurance;

automatically identifying a regulatory agency appropriate for an appeal, the identification being based upon the identified state and the type of health care insurance in the received appeal data;

generating an appeal submission comprising the data descriptive of the denial of the benefit, service or payment and arranged according to a predetermined format; and

sending the formatted appeal submission to the identified regulatory agency,

wherein the appeal relates to a request for reconsideration of a determination of entitlement to a benefit, service or payment.

Evidence Appendix

[No evidence presented]

Related Proceedings Appendix

[No related proceedings presented]